Michigan Department Of Community Health

MEDICAID VENTILATOR DEPENDENT CARE AUTHORIZATION

Complete this request with diagnosis information.

FAX TO: MDCH-Program Review Division at **(517) 241-7813**

Hospital Name

Beneficiary Name	**Facility Name**		
Beneficiary ID Number	**Facility Street Address**		
Admission Date	**Facility City**	**State**	**Zip**
Anticipated Date of Discharge to Long-Term Care	**Provider Contact Name**		
Provider ID Number	**Provider Contact Phone Number** ( ) -		
Diagnosis			
Physician's Signature	**Date**		

MDCH USE ONLY:

Prior Authorization Number

APPROVED	**DENIED**
☐ As Presented ☐ As Amended	☐

Start Date	**End Date**	**Number of Days**	**Total Daily Vent Rate**
			$

MDCH Signature Date

Authority: Title XIX of Social Security Act

MSA-1635 (03-06) Previous edition may be used.

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